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PROGRAMS FOR RURAL YOUTH--ARE THEY DOING THE JOB.

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PEOPLE LIVING IN RURAL AREAS HAVE ONLY ONE-HALF THE ACCESS PER PERSON TO DOCTORS, DENTISTS, AND OTHER HEALTH RESOURCES THAT URBAN DWELLERS HAVE. THIS IS COMPOUNDED BY--(1) THE DISTANCE BETWEEN THE PATIENT AND THE HEALTH SERVICES, (2) LACK OF TRANSPORTATION, (3) LACK OF COMMUNICATION, AND (4) LACK OF HEALTH SERVICES, PERSONNEL, FACILITIES, AND SERVICE ORGANIZATIONS. ONE METHOD OF PROVIDING BETTER HEALTH SERVICES HAS BEEN TO TRAIN NON-PROFESSIONAL HEALTH AIDES TO TEACH GOOD HEALTH PRACTICES. AN ATTEMPT TO ATTRACT PHYSICIANS TO RURAL AREAS INVOLVES COMMUNITY SUPPORT OF A PROGRAM TO CONSTRUCT A RURAL HEALTH CENTER. THE UNIVERSITY OF OKLAHOMA IS CURRENTLY DEVELOPING A PROJECT TO RECRUIT PHYSICIANS IN GROUPS, BY ESTABLISHING A STRONG TIE-IN BETWEEN A RURAL CLINIC AND A UNIVERSITY MEDICAL CENTER, AND BY ENCOURAGING LOCAL COMMUNITY ACCEPTANCE OF THE PHYSICIANS' FAMILIES. OTHER RURAL HEALTH PROBLEMS REMAINING TO BE SOLVED INCLUDE THE PROVISION FOR SAFE WATER SUPPLIES AND ADEQUATE SEWAGE DISPOSAL SYSTEMS, COORDINATION OF VARIOUS AGENCIES, GROUPS, AND INDIVIDUALS PROVIDING HEALTH SERVICES, AND HEALTH PROBLEMS OF MIGRANTS. THIS SPEECH WAS PRESENTED AT THE NATIONAL OUTLOOK CONFERENCE ON RURAL YOUTH, OCTOBER 23-26, 1967, WASHINGTON, D. C., SPONSORED JOINTLY BY THE U. S. DEPARTMENTS OF AGRICULTURE, HEALTH, EDUCATION, AND WELFARE, INTERIOR, AND LABOR, OEO, AND THE PRESIDENT'S COUNCIL ON YOUTH OPPORTUNITY. (SF)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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General Session

PROGRAMS FOR RURAL YOUTH - ARE THEY DOING THE JOB?
Health Services

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Approximately 54 million Americans or 30 percent of our population live in rural areas. These rural citizens have only one-half the access per person to doctors, nurses, dentists, and other health resources as compared with urban Americans. Only 12 percent of our physicians, 18 percent of our nurses, and 14 percent of our pharmacists are located in rural areas. The health problems of rural families are compounded further by their inability to purchase the limited services that are available. The incomes of about 15 million rural people are below the poverty level.

The death rate among non-white infants is more than 20 percent higher in rural areas than in urban areas. Seventy percent of fatal automobile accidents occur in rural areas. One out of every four deaths from work accidents is in the agriculture industry. Bed confining injuries and number of days of restricted activity due to illness and injury are one and one-half times as great among rural people as among urban people.

The health problems of rural people are compounded by (a) the distance between the patient and health services, (b) lack of transportation, (c) lack of communications, (d) lack of health services, personnel, facilities and service organizations.

As one would expect, this difference in health services available is reflected in the picture of the health status of the population in rural areas.

The impact of rural poverty on health is highlighted by the situation prevailing in the State of Mississippi, the state with the lowest per capita income in the nation. In the United States as a whole, fewer than twenty-five of every thousand children born alive die before their first birthday; in Mississippi more than forty die. Across the nation, the maternal mortality rate per 100,000 births is 33.6; in Mississippi 83 mothers die in childbirth per 100,000 births. Nearly one fourth of all children are born outside the hospital, compared with 2.6% for the nation.

States, such as Mississippi, in which the problem of rural poverty is the

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greatest, are, by the fact that they have a low economic tax base, the least able to support welfare medical services.

Major efforts in solving health problems of rural people have always been those of private physicians, private hospitals, and State and local health departments. Certainly, this approach has had a large measure of success in those areas where the economic base of the rural areas has been strong enough to support both private and public health servides.

Nevertheless, we are still faced with a shortage of physicians and other health workers in rural areas. This shortage is expected to become worse in the future as more and more health professionals settle in the big cities rather than rural areas. Our past attempts to stop the flow of physicians from rural areas to the city, in fact, to reverse this flow, have been disappointing.

One method of providing health servides to the people in isolated areas involves the use of non-professional health aides. A number of universities, State and local health departments, as well as the Federal government have developed programs whereby local people are recruited, given intensive training in the techniques of health education and then sent back to their communities to teach good health practices to their own people. Where this program has been tried, it has generally met with success. Where it has not met with success, the principal reason for failure was either a lack of professional supervision, or, unfortunately, active hostility on the part of professional health workers who felt threathened by this new group of aides.

One program of particular note has been the attempt to attract physicians to rural areas by construction of rural health centers. This has been a joint effort of the American Medical Association and the Sears Roebuck Foundation. The Sears Roebuck Foundation, upon accepting an application from a community requesting assistance, first undertakes a health resources and medical need survey of the proposed service area.

If the study indicates a medical manpower need exists and that the area can indeed support a physician, a fund raising campaign is launched with professional support from the Sears Roebuck Foundation. As the funds are raised, they are placed in escrow while building plans are developed and a building contract is let. Meanwhile, the AMA undertakes an attempt to recruit a physician to staff this clinic. When the facility is completed, and a physician has been found, the building is sold to him by the community over a long-term contract. Thus far, this program has sponsored about 150 facilities of which 140 have been staffed one or more times. As of this date, 119 are permanently staffed, which is a success ratio of 78 percent. There are about 10 hardcore problem areas where there is little likelihood of success unless future population pressures intervene.

A similar program has been carried out by the Kellogg Foundation.

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Recent studies by the University of Oklahoma, the New York State Medical Society, and others, however, have indicated that a guaranteed income or a new well-equipped office are not the primary factors which lure a physician to practice in rural areas. Major causes of physician dissatisfaction with rural practice include such problems as long, unrelieved hours, inadequate time to study or to attend meetings, lack of hospital appointments, and lack of educational stimuli generally found around hospitals, medical centers, and clinics.

Further, the absence of social, cultural, educational, and recreational opportunities for the doctor's wife and children works strongly against physicians settling in rural areas. While the physician can receive great personal satisfaction from his work among rural people, his family is frustrated by the problems of rural isolation and eventually brings pressure on him to move to the city.

The University of Oklahoma is currently developing a demonstration project to show that by recruiting physicians in groups, by establishing a strong tie-in between a rural clinic and a University Medical Center, and by encouraging local community acceptance of the physicians' families, a rural community can be successful in recruiting and retaining physicians.

Yet another system of bringing health services to rural people in isolated areas is seen in parts of the northern Great Plains where physicians and their patients are frequently linked by the use of shortwave radio and light airplanes. This approach has been systemized in the State of Alaska by the United States Public Health Service, where hospitals are linked to isolated villages by means of two-way shortwave radio. At a regular time each day a physician in the hospital is available on the shortwave radio band to give medical consultation to laymen in villages where there is no professional medical help. When indicated, air transport is available to bring the patient to the doctor or the doctor to the patient.

The provision of safe water supplies and adequate sewage disposal systems for people of rural areas has long been recognized as a valued public health measure. The responsibility for providing these water and sewage systems generally remains that of the individual householder in rural areas of the United States. County or State public health departments may provide technical assistance and may be responsible for enforcing legal standards. Unfortunately, inadequacies of local legal regulations, lack of local technical competence, and the inherent economic limitations in rural areas tend to decrease the effectiveness of attempts to promote high standards of environmental sanitation in rural areas. As one moves from the farm areas to the small rural towns, the situation is somewhat more hopeful. In small villages, there is more likely to be technical competence and tax-supported financial help to develop water and sewage systems. Furthermore, concentration into villages leads to greater efficiency of water and sewage systems.

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In recent years in the United States, obvious frank nutritional diseases such as pellagra, scurvy, rickets, kwashiorkor, and the like have been seen so rarely as to lull us into false sense of security with regard to the nutrition of our rural population. Only recently has it been realized that widespread nutritional deficiencies do exist in our rural population, particularly among the poor. These deficiencies do not manifest themselves as frank nutritional disease, but probably have long-term effects in terms of decreased productivity, both physical and mental. Our Federal government is currently doing a careful and detailed study of the nutritional deficiencies among the people of the United States, similar to studies which have been carried on elsewhere.

Perhaps the greatest problem in the development of health services for rural people has been the fragmentation and lack of coordination of the various agencies, groups, and individuals providing these health services. The National Commission on Community Health Services in a recent report recommended that -- "by deliberate planning, (communities) should develop patterns of comprehensive health services of optimum quality and assure their availability, accessibility, and acceptability to all ... (These comprehensive health services) should include a <u>full range</u> of health services" including health promotion, prevention of disease and disability, and "early diagnosis and treatment with systematic follow-up to achieve maximum physical, social, and vocational rehabilitation."

Unfortunately, however, in the past, the multiple individuals and agencies responsible for providing the segments of the health services for people in communities have had difficulty in coordinating their efforts, with many resultant gaps in service. These gaps have been wider and more obvious in rural areas than in urban areas. At this time, however, we have a particularly valuable opportunity to our country to develop a system of coordinated health services through the stimulus and financing of the Comprehensive Health Services Planning Act of 1966, which enables States and areas within States to develop plans for health services which are truly comprehensive and cover all segments of the population and all phases of health needs. This system is currently just being put into effect.

In the face of the current emphasis upon and concern for the problems of the big cities, however, it is necessary that we take special cognizance of the needs and resources of rural areas in developing our plans for comprehensive health services. Rural areas, with relatively the greatest needs for improved health services, are often also lacking the technical competence to make their needs heard in the development of comprehensive regional plans. Currently, local, State, and Federal agencies are working together to develop pilot projects in several rural areas in the country to demonstrate that the support of a professional health planner and mobilizer for rural areas will pay dividends in terms of improved efficiency of the use of health resources available to the people. These projects have not yet been completed and therefore results are not available to us yet.

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In the past the United States Government has also stimulated a comprehensive approach to the health problems of specific groups of people by specific legislation aimed at improving the conditions of these people. For example, much of the routine planting, cultivating, and harvesting of crops in our Nation is performed by migratory farm workers - one million men, women, and children who migrate several times a year from area to area in response to the needs of the agriculture industry.

These people are handicapped by poverty, lack of education, lack of readily marketable skills, poor environment, community rejection, and even more, the lack of any place to call "home." These factors have combined to keep the migrant agricultural worker and his family from enjoying the health standards of the rest of the population. For example, in 1964, when the national infant death rate was 24.8 per 1,000 live births, the infant death rate among migrant agricultural laborers was 30.6 per 1,000 live births. Other health indices show a similar disparity between the condition of the migrant and that of the rest of the population. In order to stimulate the local communities into which these migrants move to develop comprehensive health services for these people, the Federal government has offered grants to help offset the cost of providing health services for the migrants. Such health services include outpatient and impatient medical care, dental care, immunizations, public health nursing services, health education services, and sanitation services. In addition, this program has stimulated a community-wide approach to the health problems of the migrant agricultural workers by providing consultation in community organizations, medicine, nursing, health education, hospital administration, sanitation, and social sciences. While this program has only been in operation for a few years, it has already had the impact of stimulating the development of health services for migrants in many parts of the country.

An interesting and effective approach to the provision of comprehensive health services to limited groups of rural people has been under way among the Indian population still living on Federal Reservation land. The responsibility for the health of the Reservation Indians in our country has for years been that of the Federal government. A new approach was started in 1955 when the United States Public Health Service started to develop comprehensive health services programs for these people. In the 12 years of operation of this program, great strides have been taken. From 1954 to 1964, the infant death rate among Indians fell from 65 (per 1,000 live births) to 36; among Alaskans from 83.4 to 54.8. The tuberculosis death rate fell from 54 (per 100,000) to 21. Even more dramatic was the fall in tuberculosis death rates among the Alaska natives under the same program - from 236 to 18. Our experience in improving the health of our Indian people has shown us that, if we marshal our resources and focus upon the problem, the health of special groups of rural people can be improved significantly.

Health services for needy youth are available through State agencies

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from:

Children's Bureau
Vocational Rehabilitation
Title XIX of the Social Security Act

Under the Head Start program funded by the Office of Economic Opportunity, limited medical and dental services are available to the children enrolled in these programs.

Under Section 202 of the Appalachian Act multicounty demonstration health projects will be funded. These projects will meet a variety of needs including new facilities, acquiring facilities, underwriting operation deficits, staffing, training health service personnel, emergency services, etc.

Examples of Public Health Service programs for the general population which improve health services to rural youth are:

A. Grants to assist in the construction of needed health facilities. Hill-Burton hospitals are continually improving the facilities and services available to the rural population.

B. Grants to medical schools for training physicians, dentists, nurses and allied professional health workers.

C. Grants for studies, research, and demonstration in new or improved methods of providing health services to rural communities.

D. Assignees to States to assist in developing or expanding health and health-related services.

E. Grants to State and local public and voluntary agencies to establish rural mental health services.

F. Studies of the distribution of health personnel and facilities.

G. Technical assistance in community surveys of health and health-related needs and services; and in development of adequate planning follow-up on high priority health needs.

The Bureau of Health Services has recognized the problem of the rural disadvantaged and has placed high priority on obtaining a solution. Two problems have been specifically cited for top priority:

1. The inequitable geographic distribution of health services resources.

2. The disparity in certain disadvantaged groups between health needs and health demands. The five-year plans of the Bureau of Health Services call for vast increases in health services sup-

port for special groups between 1968 and 1973. The majority of this money will be directed at rural and migrant health programs.

Programs designed significantly to affect the health of any group must be integrated into a comprehensive attack on the problems facing that group. Social factors, affecting health are complex and deeply rooted. Therefore, comprehensive health programs must of necessity be coordinated with programs designed to reduce the adverse effects of social factors.

In achieving what we can today, we must be building and revitalizing cooperative efforts between Federal, State, and local health and health related agencies and groups that will assure continuing progress.